MISSOURI DEPARTMENT OF MENTAL HEALTH

LEGISLATOR BRIEFING

January 2020

Mental Health Highlights and Issues

I. DMH: Your Partner in Public Service

The Department of Mental Health is a safety net, human services organization delivering programs and services to Missouri's most vulnerable citizens. Our staff is innovative, collaborative and mission driven, but, above all, committed to excellence in public service.

CONSTITUENT ISSUES

As an elected official, you may receive inquiries regarding DMH services from your constituents. All constituent needs and concerns are a priority for us. Here is our process for constituent issues plus tips on information your office can provide to expedite the process.

What we need:

- As much concise/precise detail as feasible, preferable by email.
  - Name, address, phone number, email of constituent.
  - Consumer full name, along with age or birthdate.
  - Services the person is receiving or seeking.
  - Concrete concerns about a provider or program.
  - Any deadline or timeframe they are addressing.
- Ask what they specifically want/need from you and from DMH. Sometimes constituents just want to vent to you about a personal situation which cannot be addressed by public servants.
- If they are difficult or upset, connect them with the Access/Crisis Intervention (ACI) line (see link below under Resources).

What we do with the information you provide:

- Check our system and appropriately follow-up with existing consumers:
  - Wellness check.
  - Investigate complaints or concerns.
  - Provide families/concerned citizens with educational information and resources on programs and services available through DMH.
- Triage with other agencies and partners.
  - Many constituents receive services from multiple agencies; DMH, DSS and DHSS frequently share/refer/problem solve.

Restrictions:

- Health Insurance Portability and Accountability Act (HIPAA)—without permission from the person under care, we cannot discuss mental health records with anyone who is not authorized to review that information.
- DMH has no authority or influence with programs/services/providers that do not contract with us such as those who only accept private insurance.
- DMH cannot referee family disputes or issues with the public administrator but there are resources that can.

Resources:

- DMH ACI Line—listing by county of toll-free connection to a mental health professional 24/7
- Legal Aid—for constituents who cannot afford an attorney www.lsmo.org
- Protection and Advocacy—for constituents who have complaints against state agencies and need an advocate www.moadvocacy.org

HELP US COMBAT STIGMA

Join us in following the guidance of People First Language.

Rule 1. Call the person by their name.
Rule 2. If you speak with someone living with a health or mental health disability, remember to speak to the person first and then the disability second. Here are some examples:

Say:	Instead of:
People with disabilities	The handicapped or disabled
Bob's son has autism	Bob's autistic son
Susan's daughter has Down Syndrome	Susan's Down syndrome daughter
Brain injury	Brain damaged
Accessible parking, hotel room, etc.	Handicapped parking, hotel room, etc.
Deb uses a wheelchair/mobility chair	Deb is confined to a wheelchair or is wheelchair bound
Jim has bipolar disorder	Jim is bipolar
Mark has a substance use disorder	Mark is an alcoholic (or druggie, pothead, substance abuser, etc.)

Words to Avoid

Harmful words are the driving force behind stigma. Words and phrases can impact how someone lives their life by making them feel not "good enough" or "less than" others. Follow these links to our website for words to use and avoid in conversation.

Behavioral Health and Developmental Disability Language

Substance Use Disorder Language

Thank you for being our partner in public service and choosing respectful language to assist our mission to reduce stigma.

AMBASSADORS ACADEMY

To learn more about the Department and how we can assist your constituents, join us for our Ambassadors Academy each fall at the Capitol. DMH leaders and partners share behavioral health and developmental disabilities updates and program innovations making a difference for Missouri's most vulnerable citizens. Lean more about this educational forum here

II. Department of Mental Health Overview

The Department of Mental Health (DMH) annually serves more than 170,000 Missourians with mental illness, developmental disabilities, and substance use disorders. It is a safety net for the state's most vulnerable citizens and their families. Our primary populations include:

- **Adults with serious mental illness and children with severe emotional disorders**
- **People with developmental disabilities**
- **People with severe substance use disorders (SUDs).**

Community-based contract providers serve more than 95% of these individuals. Approximately 60% are Medicaid eligible.

MENTAL HEALTH COMMISSION

The seven-member Mental Health Commission appoints the DMH director with Senate confirmation. Commissioners serve as the principal policy advisers to the department. The Governor with Senate confirmation appoints commissioners to terms of varying length.

Commission member positions must include individuals who represent Missourians with mental illness, developmental disabilities, and substance use disorders, and who have expertise in general business matters (630.010 RSMO).

DMH MISSION (RSMO Chapter 630.020)

Prevention: Reduce the prevalence of mental disorders, developmental disabilities, and substance use disorders.

Treatment and Habilitation: Operate, fund, and license or certify modern treatment and habilitation programs provided in the least restrictive environment.

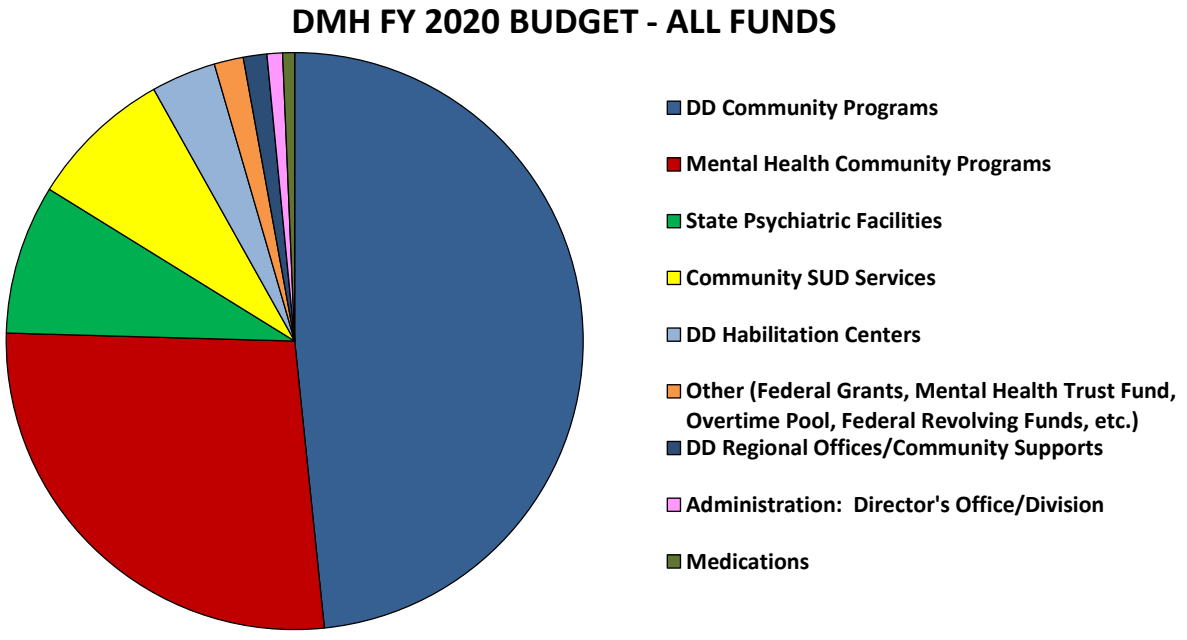
Improve Public Understanding: Improve public understanding and attitudes toward individuals with mental illness, developmental disabilities, and substance use disorders.

DMH DIVISIONS

- **Division of Behavioral Health (DBH) –** RSMO Ch. 631 and RSMO Ch. 632
  (formerly the divisions of Alcohol and Drug Abuse and Comprehensive Psychiatric Services)
- **Division of Developmental Disabilities (DD) –** RSMO Ch. 633
- **Division of Administrative Services**

III. FY 2020 DMH Budget by Program Category

Budget Category	Amount	% Total	FTE
DD Community Programs	$1.191 billion	48.36%	25 FTE
Mental Health Community Programs	$667 million	27.09%	32 FTE
State Psychiatric Facilities	$206 million	8.37%	3,767 FTE
Community SUD Services	$199 million	8.06%	29 FTE
DD Habilitation Centers	$89 million	3.63%	2,456 FTE
Other (Federal Grants, Mental Health Trust Fund, Overtime Pool, Federal Revolving Funds, etc.)	$41 million	1.63%	10 FTE
DD Regional Offices/Community Supports	$33 million	1.32%	694 FTE
Administration: Director's Office/Divisions	$21 million	0.87%	221 FTE
Medications	$16 million	0.67%	0 FTE
TOTALS	$2.463 billion	100.0%	7,234 FTE



- In FY 2020, the DMH budget is 8% of the total state operating budget.
- DMH generates $301 million per year in reimbursements from Medicaid, Medicare, disproportionate share (DSH) and other third party pay.
- Approximately 62% of all DMH GR funding is used as state match for services funded through the Medicaid program.

DMH CONTRACTED SERVICES

- DMH contracts with more than 1,400 provider agencies employing 30,000 people statewide.
- More than 95% of the Department of Mental Health's 170,000 consumers receive their services through contracted community-based provider agencies.

STATE OPERATED SERVICES

BEHAVIORAL HEALTH	DEVELOPMENTAL DISABILITIES
6 hospitals for adults 1 hospital for children	4 state-operated habilitation centers 2 community support agencies 1 crisis community support agency 5 regional offices, 6 satellite offices

State operated services in the Behavioral Health division include the Sex Offender Rehabilitation and Treatment Services (SORTS) program for sexually violent predators. The SORTS program is located at Southeast Missouri Mental Health Center in Farmington and at Fulton State Hospital.

IV. DMH Program Highlights and Critical Issues

PROGRAM HIGHLIGHTS	CRITICAL ISSUES
• **Avoiding Crisis for BH/DD Individuals** • **Evidence-Based Practices of Treating Substance Use Disorders-Medication Assisted Treatment** • **Justice Reinvestment Treatment Pilot** • **Excellence in Mental Health Act's Certified Community Behavioral Health Organizations (CCBHO) Prospective Payment System Demonstration Project** • **Missouri Model of Crisis Intervention** • **Suicide Prevention Efforts**	• **Preventing the DD Wait List** • **Critical Clinical/Direct Support Professionals Staffing Shortages** • **Employment** • **Opioid Crisis** • **Provider Rate Inequities** • **State Inpatient Facility Capacity** • **Uninsured Individuals Seeking Services**

PROGRAM HIGHLIGHT: Avoiding Crisis for BH/DD Individuals

Every year people with both a behavioral health disorder and a developmental disability are referred to DMH. Some of these individuals do not fit into the current community service delivery system funded by the Department. Leaders of the Divisions of Behavioral Health and Developmental Disabilities are working together with providers to build systems ensuring individuals served by both Divisions receive effective services. These efforts include:

- Department leadership prioritizing effective services by establishing cross agency standards of best practice;
- A Department of Mental Health taskforce is developing Clinical Best Practice guidelines for individuals with co-occurring DD/BH needs. Dr. John Constantino, Psychiatrist-In-Chief of St. Louis Children's Hospital and Director of William Greenleaf Eliot Division of Child Psychiatry and Intellectual and Development Disabilities Research Center at Washington University, and Dr. Kristin Sohl, Associate Professor Clinical Child Health, Medical Director Show Me ECHO, Missouri Telehealth Network, University of Missouri are chairing the Missouri Alliance for Dual Diagnosis (MOADD) which includes community providers. The task is addressing the needs of this difficult-to-treat population by:
    - Developing a MOADD Mobile Application for use by clinicians
    - Developing best practice guidelines
    - Publishing these results in a peer-review journal
- Dedicated staff performing risk assessment, identifying systemic interventions, reducing crisis events;
- Training and coaching for contracted agencies to prevent crisis events;
- Pilot implementation of the Department's Co-Occurring Protocol-coordinating services across Divisions;
- Increased enrollment of DBH providers into the DD system;
- Accessing the established, successful DBH crisis system.

Additional funding will be necessary to provide the full continuum of care for these individuals. The additional funding is needed to:

- Build capacity for implementation of preventative strategies;
- Expand implementation of best practices by qualified providers;
- Develop an intensive behavioral respite for adults and children offering options other than the emergency room or jail;
- Create an intensive behavioral residential service for adults and children that are unsuccessful living in the community;
- Expanded coordination of services provided by the two Divisions.

PROGRAM HIGHLIGHT: Evidence-Based Practices in Treating Substance Use Disorders - Medication Assisted Treatment

Substance use disorders (SUD) are chronic medical conditions and should be managed like diabetes and heart disease. New medications can be very effective in treating opioid and alcohol use disorders. These medications drastically reduce cravings and allow the individual to focus efforts on non-medical clinical treatment services. Individuals using medications for substance use disorders can become employed, attain stable housing, reduce criminal activity and rebuild relationships. In state-funded programs, the number of individuals receiving such medications for Opioid Use Disorder (OUD) or Alcohol Use Disorder (AUD) has increased by 53% in the last three fiscal years.

Between FY17 and FY19, DMH has seen the following impacts of addiction medications:

- The length of service for individuals receiving addiction medications for OUD or AUD has increased by more than 30 days on average. Research indicates that most individuals need at least three months of treatment to significantly stop or reduce their use and that the best outcomes occur with longer durations of treatment.
- While the percentage of individuals using medication for an OUD or AUD has increased, the percentage of individuals receiving detoxification or residential services has decreased at a similar rate. Individuals served with addiction medications experience less disruption to employment and familial relationships while receiving treatment.

For individuals with Medicaid diagnosed with an OUD or AUD, between FY17 and FY19, the following data emerged:

- For the last three years of service follow-up, a person who received medications in a given year **visited the emergency department during the next fiscal year at a much lower rate** than those who did not receive addiction medications.
- For the last three years of service follow-up, a person who received medications in a given year had **fewer hospital stays, on average,** during the next fiscal year than those who did not receive addiction medications.
- The **average total Medicaid cost for a person with OUD or AUD is much less** in the year following service for those individuals that receive addiction medications than it is for those that do not receive these medications.

Long-term treatment with FDA-approved OUD medications (*predominantly buprenorphine and methadone*) combined with psychosocial supports (*i.e. counseling and recovery supports*) are the most effective in managing this chronic illness. However, physicians receive insufficient training on SUD treatment protocols in medical school, and federal restrictions are significant. Buprenorphine can only be prescribed by specially trained physicians (*known as "waivered physicians"*) and their caseload is limited to 30 patients in year one and up to 275 patients in year two. Advanced practice nurses are federally approved to prescribe buprenorphine, but in Missouri APRNs are restricted to a 30-day prescription and required to be in a collaborative relationship with a waivered physician. Methadone has a long history of success, yet can only

be prescribed within specialty opioid treatment programs (OTPs), which further limits access. There are not similar requirements to use the medications approved for the treatment of AUD.

Unlike medications for other chronic illnesses, medications for SUDs have been adopted slowly, primarily because of the lack of education for prescribers and the general public. Despite the resistance in some parts of the country to using these medications, Missouri is nationally recognized as a leader in employing Medication Assisted Treatment (MAT) for SUDs. For many individuals, these medications have literally been lifesavers. However, as with all services for individuals with SUDs, the demand for treatment interventions far exceeds the available resources.

For more information visit https://dmh.mo.gov/alcohol-drug/medication-assisted-treatment and http://www.missouriopioidstr.org/.

PROGRAM HIGHLIGHT: Justice Reinvestment Treatment Pilot

In 2017, Missouri leaders requested and received support from the U.S. Department of Justice, Bureau of Justice Assistance (BJA) to employ a Justice Reinvestment Initiative (JRI) approach to study the state's criminal justice system with technical assistance from the Council of State Governments (CSG). Missouri passed JRI legislation in 2018 and an executive level JRI Taskforce sets policy and oversees the project. Three key findings emerged from a comprehensive data analysis of state agencies: 1) there was an increase of violent crime, 2) there were high recidivism rates among individuals on probation or parole, and 3) there was insufficient behavioral health treatment for individuals under supervision.

DOC and DMH collaborated to implement the JRI Treatment Pilot (JRITP) which established a community behavioral health program to provide comprehensive community-based services for individuals who have substance use and co-occurring (substance use and mental health) disorders, under the supervision of DOC, and are considered high risk for reoffending. The pilot launched September 2018 in Boone, Buchanan and Butler counties based upon the high recidivism and violent crime rates. The pilot was expanded to Greene and Polk counties in December 2019. The overarching goal of JRITP is to provide effective and individualized treatment services that address criminogenic needs and risk factors in order to lower crime, decrease system costs, and contribute to a safer, healthier Missouri. As of September 30, 2019, over 380 clients have been served by JRITP.

PROGRAM HIGHLIGHT: Excellence in Mental Health Act's Certified Community Behavioral Health Clinics Prospective Payment System Demonstration Project

Certified Community Behavioral Health Organizations (CCBHO) developed from the Excellence in Mental Health Act, co-sponsored by Senator Roy Blunt, created a demonstration program that created national standards and allowed for cost-related reimbursement. Agencies designated by the Division of Behavioral Health (DBH) as a CCBHO are part of a demonstration project that

moves select Missouri providers from a fee-for-service system to a Prospective Payment System (PPS). The demonstration award provides an enhanced federal match during the demonstration period for the CCBHOs and is similar to the Federally Qualified Health Center (FQHC) model of service and reimbursement. CCBHOs provide the most comprehensive array of integrated, evidence-based behavioral health services for individuals with serious mental illnesses and substance use disorders. Missouri was one of 24 states to receive a planning grant to develop an application for the demonstration. DMH, DSS and OA ITSD collaborated on a successful application and a demonstration implementation project which was awarded in December 2016 to Missouri, one of only eight states to receive an award. Missouri began the demonstration on July 1, 2017, with 15 Community Mental Health Centers participating. Initial outcome results indicate that CCBHOs increase the numbers of individuals served, significantly decrease wait times for appointments and provide opportunities for service delivery in venues that did not previously exist (e.g., criminal justice agencies and schools).

The Department is actively engaged in sustainability planning, looking towards the transformation of more Community Mental Health Centers into CCBHOs, as well as changing the reimbursement model for other DMH behavioral health providers to a PPS. This year the Department expects to have an approved state plan amendment for CCBHCs through the Centers for Medicaid and Medicare (CMS). For more information visit https://dmh.mo.gov/certified-community-behavioral-health.

PROGRAM HIGHLIGHT: Missouri Model of Crisis Intervention

The Missouri Model of Crisis Intervention represents a partnership between law enforcement, the Department of Mental Health, the Missouri Coalition for Community Behavioral Healthcare and community stakeholders. It addresses the needs of individuals in crisis with a focus on the right interventions provided in the right way at the right time to improve outcomes and efficiently manage resources. The Missouri Model will become the national standard for assisting individuals with mental illness and substance use disorders who are in crisis. Launched in 2013 the components of the Missouri Model are:

- **Crisis Intervention Team (CIT) Training**
  - More than 10,000 law enforcement personnel have been trained on how to approach and assist individuals who are experiencing a crisis due to mental illness, substance use or developmental disability. Currently, CIT Councils cover 100 counties in Missouri. The State CIT Council recently developed the Missouri Model for CIT Training.
- **Community Mental Health Liaisons (CMHLs)**
  - Statewide, 31 Liaisons based at community mental health centers work with local law enforcement and court personnel to connect people experiencing behavioral health crises to treatment and community services.
  - CMHLs have referred over 62,000 individuals in crisis for services. CMHLs have provided more than 900 trainings on behavioral health topics with over 13,400 officers

trained. These trainings are provided at no cost to law enforcement and are Peace Officer Standards and Training (POST) certified.

- **Emergency Room Enhancement (ERE) Projects**
  - In 2017 ERE projects expanded from the original seven regions of the state to include an additional five areas; ERE expanded to an additional area in 2018.
  - More than 9,105 individuals have received services — the majority of participants identified at least one: mental health concern (95%), substance use concern (84%), or physical health concern (80%).
  - Individuals who remained engaged in treatment for six months showed a 77% reduction in ER visits, 74% decrease in hospitalizations, 49% reduction in law enforcement contacts, 67% decrease in unemployment, and a 59% reduction in homelessness.
- **Mental Health First Aid (MHFA) Training**
  - Over 53,000 Missourians have been trained in MHFA, a national program that teaches participants about the signs and symptoms of specific illnesses like anxiety, depression, schizophrenia, bipolar disorder, and addictions.

PROGRAM HIGHLIGHT: Suicide Prevention Efforts

Suicide rates continue to rise each year in Missouri; increasing by 40% since 2009. Over the past few years, the Department has increased suicide prevention efforts and in 2017, Missouri ranked 18th highest in the nation, down from 14th.

- All Missouri community mental health centers are trained in the Zero Suicide program and implementing suicide safer care practices.
- The contracted Prevention Resource Centers have trained over 240 schools in the Signs of Suicide (SOS) curriculum.
- DMH partners with the National Crisis Text Line to promote the free text number to youth in Missouri.
- In 2016, DMH was awarded a Youth Suicide Prevention grant and has since served over 1,000 youth in the Kansas City area.
- In 2018, DMH was awarded a Zero Suicide Grant to expand the framework into multiple health systems and improve care coordination. Pilot projects serving adults at risk of suicide are taking place in St. Louis and Kansas City. Within the first year of implementation this project served over 300 adults at risk of suicide.
- DMH and the Missouri Coalition for Community Behavioral Healthcare partnered to create the **Missouri Suicide Prevention Network (MSPN)** bringing together experts from around the state to lead and coordinate efforts.
- In 2019, DMH collaborated with the MO Coalition for Community Behavioral Healthcare and Community Counseling Center to host regional Suicide Prevention Conferences in

Kansas City, Columbia and Cape Girardeau. Over 1,200 participants including licensed professionals, legislators, and community members attended. Planning has already begun for the 2020 regional Suicide Prevention Conferences.

CRITICAL ISSUE: Preventing the DD waitlist

The FY 2020 budget re-introduced the Division of Developmental Disability waitlist. The Division had not operated with a waitlist since FY 2014. DD implemented a waitlist for waiver services on July 1, 2019. The Governor Recommended budget included $30.3M for 1,302 individuals with disabilities to access both residential and in-home services The TAFP budget included only $8.5M, funds services for 444 individuals in this fiscal year. In-home services will be limited to 30 new individuals a month and residential services will be limited to 5 new individuals per month. (Residential services are the most costly services funded by the division, and historically 23 people per month have been added.) As of December 2019, 452 individuals were on the in-home waitlist and 97 individuals were on the residential waitlist. In FY 2021, the Division is requesting $26.1 million general revenue to serve an additional 2,823 individuals who present for services and who are Medicaid eligible.

CRITICAL ISSUE: Critical Clinical/Direct Support Professionals Staffing Shortages

Missouri state-operated facilities and contracted providers are experiencing extreme shortages in clinical staff such as psychiatrists, nurses, psychologists, social workers, counselors, behavior analysts and direct support professionals (DSP). Behavioral difficulties of patients, poor working environments, increased mandatory overtime and high turnover result in employee injuries and impact quality of care. Public sector salaries fall 30% or more below private health care industry salaries. DSP salaries, compared to those in 21 other states, are 89 cents per hour lower in Missouri. DSPs are paid on average $10.95 per hour. The hourly pay to keep a family of four at the poverty level is $11.00. Key concerns include:

- Missouri ranks the fifth highest in the nation, having 266 areas facing shortages of mental healthcare professionals, according to the Kaiser Family Foundation. The ranking is based on a quarterly summary of designated Health Professional Shortage Area statistics published September 30, 2019, by the Bureau of Health Workforce and the Health Resources and Services Administration. This designation is given to areas where the population-to-psychiatrist ratio for mental healthcare is at least 30,000 to 1.

- Mental health salary and retirement benefits offered for clinicians are no longer competitive; neither are recruitment and retention benefits, nor college tuition payback strategies.

- Turnover/vacancy rates of DMH facilities are more than double the national and state averages for nurses and other professional staff.

- Turnover and vacancy rates for direct care staff are increasing. In FY 2019, the turnover rate for direct care staff working in high security at Fulton State Hospital was 50%, resulting in less experienced staff working at Missouri's only high security psychiatric hospital.
- Across all hospitals, the vacancy rate for Psychiatric Technicians was 14%.
- In September 2019 the average vacancy rate for RNs was 26% and for LPNs the rate was 34%. The vacancy rate for RNs at Fulton State Hospital was 46% and the vacancy rate for LPNs was 55%, despite moving into the new Nixon Forensic Center.
- Overall, 46% of unlicensed psychiatric technician and security aide staff have less than three years of state employment, compared to 44% in 2018. About 39% of all aides working in a high security environment had less than three years of state employment. These findings suggest that our paraprofessional workforce continues to be inexperienced when working with the state's highest risk psychiatric patients.
- DMH is implementing the Caring for Missourians Mental Health Initiative to improve the recruitment of licensed professionals and retention of quality staff.
- In 2018, Missouri providers of services for individuals with developmental disabilities experienced a 53.4% turnover rate for DSPs and a 6.6% vacancy rate. Only 62.8% of staff delivering services had been doing so for more than 12 months; Survey data covers over 15,000 Missourians employed as a direct support professional.

CRITICAL ISSUE: Employment

At a time when Missouri is experiencing a statewide workforce shortage, the workforce participation rate for individuals in treatment for serious mental illness (11.4%), substance use treatment (34%) and intellectual/developmental disabilities (9.5%) are considerably lower than that of the general population (63.2%).

The Department of Mental Health is committed to assisting bridge the labor gap and improve quality of life of the individuals we support. The importance of employment is evidenced by research which has demonstrated the correlation between employment, improved health and decreased health care costs.

In December 2019, DMH was selected for the fifth consecutive year for technical assistance from the US Department of Labor's Office of Disability Employment Policy with public policy design to increase the employment rate of individuals with disabilities. As part of this effort, DMH partnered with the Governor's Office, Office of Administration, Missouri Chamber of Commerce and 8 state departments on the implementation of Missouri as a Model Employer – which culminated in Executive Order 19-16. In addition to the EO, training was developed for state HR directors, a survey of Missouri's state workforce and a Talent Showcase (job fair) featured 50 job seekers with disabilities meeting directly with 86 human resource and hiring managers to fill workforce needs.

The DD employment initiative, Empowering through Employment, is a statewide effort with a target goal of supporting 3,700 individuals with employment pathways. Since the launch of the initiative, there has been a 184% increase in the number of individuals accessing employment supports. In addition, 21 private service providers have received training and technical assistance on increasing the quality and effectiveness of employment services and over 300 employment support professionals have participated in a monthly community of practice to enhance employment outcomes.

For more information, visit: dmh.mo.gov/dev-disabilities/programs/promoting-employment

In 2009, DBH in partnership with Vocational Rehabilitation, implemented Individualized Placement and Support (IPS), a supported employment, evidence-based practice for individuals with serious mental illness. IPS services are provided in 26 IPS programs (functioning at 31 sites) with six emerging programs. In 2019, 1,200 individuals received IPS with 47% successfully employed. Vocational Specialists serve on nine adult Assertive Community Treatment Teams and eleven Assertive Community Treatment Teams for Transition Aged Youth (TAY). Additionally, Community Support Specialists on Community Psychiatric Rehabilitation teams provide services to support the employment goals of individuals served. In 2018, Employment Specialists were added to the Justice Reinvestment Initiative six treatment sites and three Recovery Community Centers.

For more information visit https://dmh.mo.gov/mental-illness/employment-services.

In December 2019, DD and DBH were selected, for the fifth consecutive year, as a recipient of the US Department of Labor's Office of Disability Employment Policy's *Employment First State Leadership Mentoring Program*. By participating in this program, DD and DBH continue to enhance the systems and service structures in affirming employment rights and opportunities for individuals we serve. A Memorandum of Understanding has been signed by multiple state agencies to collaborate on Employment First for persons with disabilities.

For more information visit https://dmh.mo.gov/dd/progs/employment.html.

CRITICAL ISSUE: Opioid Crisis

Missouri is impacted heavily by the opioid crisis. Deaths associated with opioid overdoses have been rising exponentially, fueled by excessive opioid prescriptions beginning in the 1990s combined with the increased availability of cheap, pure heroin. Drug poisoning is now the leading cause of accidental death in Missouri, ahead of motor vehicle crashes, and is the leading cause of death among individuals aged 25-44 years worldwide.

There were 1,132 overdose deaths in 2018 in Missouri, up 19 % from the previous year. Seventy-five percent of statewide opioid overdose deaths were attributable to fentanyl, and more than 90 percent were attributable to fentanyl in the St. Louis region. The percent of opioid overdose deaths attributable to fentanyl has increased each year since 2014. From 2017 to 2018, the number of opioid overdose deaths attributable to fentanyl increased 13% (from 62% to 75%). Fentanyl overdose deaths are more highly concentrated in the Eastern region of the state, including the St. Louis region. In 2018, the opioid overdose death rate (per 100,000) was

approximately 57 among Black males, 22 among White males, 20 among Black females, and 11 among White females. The death rate among Black males was more than double that of White males, almost three times that of Black females, and more than five times that of White females. Furthermore, from 2017 to 2018, the overdose death rate increased at a greater rate among Black males relative to any other demographic group (from 42 per 100,000 in 2017 to 57 per 100,000 in 2018).

Two Federal grants are making a difference. In May 2017, Missouri was awarded a two-year, $20 million dollar grant, called the Opioid State Targeted Response grant. In October 2018, Missouri was awarded a two-year, $36 million dollar grant, called the State Opioid Response (SOR) grant to address the opioid crisis in Missouri at the prevention, treatment, and recovery services levels. The purpose of Missouri's SOR project is to continue and build upon the system changes for opioid use disorder (OUD) prevention, treatment, and recovery that have been activated by Missouri's STR grant. Our focus is reaching high-risk and vulnerable populations (*postpartum women, justice- involved persons, racial minorities, active drug users, individuals in rural areas, at-risk youth, etc*.). The majority of grant funds are dedicated to direct treatment services to individuals utilizing medication-assisted treatment for OUDs. The grant also invests significantly in prescriber education regarding the use of addiction medications, to build capacity within communities over the next two years. Prevention and recovery support services are also critical grant components. Through the state opioid grant projects, 21,578 individuals have been trained in overdose education and naloxone distribution, and 44,370 boxes of naloxone have been distributed. From December 2016 through December 2019, we have received 4,583 reports of lives that have been saved by naloxone. Individuals administering naloxone to save a life range from emergency responders to loved ones of those battling addiction to strangers.

While federal funds have helped frame Missouri's multi-faceted response to the opioid crisis, they cannot support the sheer numbers of individuals needing assistance, which include people with OUDs, and the systems that are attempting to help address the crisis. And federal funds to address the opioid crisis are only assured for two years. Long-term treatment with FDA-approved medications for OUD, most notably buprenorphine and methadone, combined with psychosocial services, are shown to be most effective in managing this chronic illness. However, federal requirements result in significant restrictions to the use of these medications, and physicians receive insufficient training on the treatment of substance use disorders (SUD) in medical school. Buprenorphine can only be prescribed by specially trained physicians who then are limited in the number of individuals they can treat (30 patients in year one, up to 275 in year two). Although federally approved to prescribe buprenorphine, advanced practice nurses in Missouri are restricted to a 30-day prescription and are required to be in a collaborative relationship with a waivered physician. Methadone, another medication with a long history of success, can only be prescribed within specialty opioid treatment programs (OTPs), which further limits access.

- **<u>Engaging Patients in Care Coordination (EPICC)</u>**

  - **Peer Recovery Coaches** working with Emergency Departments (ED) assist people who have overdosed on opioids in establishing immediate linkages to substance use

and addiction medication treatment services. The goals are to engage patients during emergency room stabilization with medications and substance use treatment services and to coordinate care to reduce future ER visits, overdoses and deaths.

- With the support of federal opioid grants, the Behavioral Health Network (BHN) of Greater St. Louis, in partnership with Behavioral Health Response (BHR), provides a Peer Recovery Coach who responds to the ED to meet with an individual recovering from an overdose to schedule an intake appointment for initiation of addiction medications and additional substance use disorder treatment services. With the support of State appropriated funds, and in partnership with the Missouri Hospital Association and DMH treatment providers, the EPICC project has been able to expand to the Central, Southwest, and Kansas City regions of the State.

  For more information visit https://dmh.mo.gov/opioid-crisis-response https://dmh.mo.gov/opioid-crisis-response.

CRITICAL ISSUE: Provider Rate Inequities

Community-based services contracts comprise 80% of the Department's total budget yet serve more than 95% of DMH consumers. During the past 20 years, provider reimbursement rates lagged behind inflation due to the state's failure to adjust them each year. Providers struggle to meet costs for food, fuel, insurance and proper staffing; a 1.5% core reduction and an additional 1.5% expenditure restriction, eliminated the COLAs appropriated in FY 2016 and FY 2017. In FY 2018 budget, 1.5% COLA was restored.

- The following information shows how far contracted community providers have fallen below inflationary growth over the last ten years:

  - **DBH Contracted Providers for substance use disorder services 25%**
  - **DBH Contracted Providers for mental illness services 27%**
  - **DD Contracted Providers 24%**

- The community-based agencies face daunting challenges in recruitment and retention of qualified staff in clinical and direct care positions. It is difficult for community providers to compete with the US Department of Veterans Affairs and private health care organizations. Even in years where annual inflationary adjustments have been made, the costs of medicine, food, transportation and communication far exceeded the inflationary adjustments.

- DD procured a third-party rate study for residential services. DD residential providers would need $56.5 million of General Revenue funding to standardize rates for all individuals served and to enable them to compete in the current labor market to hire and keep qualified DSPs. When DD providers standardize and improve rates, 67% of those rates fund staff salaries, 20% of rates paid support employee-related expenses and 13% of the rate will fund other service related costs and administration.

- In 2019, the Centers for Medicaid and Medicare Services (CMS) approved a corrective action plan requiring the Division of DD to standardize the residential habilitation rates across all individuals in services and providers. The approved plan allows Missouri to work toward standardized rates over 4 years (fiscal years 21-24) at a level mutually agreed to by CMS and the State. The rates paid to providers directly affects the wage that can be paid to direct support staff since the majority of the rate goes to direct care staffing and related employee expenses.
- Additional funding provided in the FY 2020 budget allowed the division to raise the lowest rates to 77.7% of the lower bound rate. The FY 2021 budget request includes an additional $58.1 million, applied to the lowest rates for each rate allocation score, these additional dollars will raise the lowest rates to 85.5% of the lower bound rate established through Mercer which has been adjusted for inflation to FY 2020.

In FY 2014, DD received $23.4 million ($8.9 million GR) to address residential provider rate issues. Funding was targeted to begin to standardize the lowest rates for individuals who have similar service needs. This has allowed the Division to move from a contracted/negotiated rate per provider to a standardized rate for serving adults with developmental disabilities.

In FY 2017, DD received $80 million ($29 million general revenue) to standardize rates and to fund a 2% inflationary increase for residential, day service, and personal assistance providers. This funding allowed the division to standardize day service rates, almost equalize personal assistance rates to the Department of Health and Senior Services and move residential rates to 70% of funding needed for rate standardization.

In FY 2018, DD received $9.8 million ($3.5 million general revenue) to standardize DD rates; however, this funding was placed in expenditure restriction, and was core cut in the FY 2019 budget. In FY 2019, DD received $2.8 million ($1 million general revenue) to standardize rates, and funding to restore 1.5% COLA. In FY 2020, DD received $58.4 million ($20.1 million general revenue) to standardize rates, and funding for 1.5% COLA for providers excluding residential waiver services.

CRITICAL ISSUE: State Inpatient Facility Capacity

Division of Behavioral Health inpatient hospitals are continually at absolute capacity and must schedule admissions for individuals committed by the criminal courts who have been found incompetent to stand trial. The list of scheduled admissions has been increasing over the last several years and typically has around 95 individuals waiting admission. DBH has begun using alternative options for individuals with behavioral health conditions who become involved in the criminal justice system such as outpatient competency restoration.

CRITICAL ISSUE: Uninsured Individuals Seeking Services

It is very difficult for many Missourians to access behavioral health services, and it is particularly hard for those without insurance.

- Budget reductions in recent years have dramatically reduced the state funding available for uninsured individuals, resulting in DMH serving mostly people who are covered under Medicaid. While this stretches state dollars, it dramatically limits services for people who do not have health insurance or who have exhausted their insurance benefits. Many people who have substance use disorders or are in the early stages of serious mental illness often do not qualify for Medicaid:
    - Some college students experiencing serious mental illness like schizophrenia, bipolar disorder, or major depression do not have health insurance and are not Medicaid eligible.
    - Of the people leaving the Department of Corrections (DOC), 83% have histories of moderate to severe substance use disorders, 19% have serious mental illnesses, and most are not Medicaid eligible; yet their conditions of parole often require that they obtain behavioral health treatment.
    - Of all individuals seeking treatment for substance use disorders through department funded providers in FY19, 60% had no insurance. For those seeking treatment for serious mental illness, 20% did not have insurance.
- Without appropriate access to services, many people experiencing a behavioral health crisis seek help at emergency rooms, get in trouble with the law, become dangerous to themselves or others, and/or experience repeated hospitalizations.
- If treatment and recovery supports are not accessible through DMH, then hospitals, jails, DOC, police departments, and physicians provide patchwork services that often are inappropriate, expensive, and leave the individual without necessary follow-up care, creating a dangerous and costly cycle.

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